RESET FORM

United States Probation and Pretrial Services
Western District of Oklahoma
Chain of Custody for Drug Analysis

* REQUIRED (FAILURE TO COMPLETE WILL DELAY PROCESSING)

*Offender/Defendant Name (last, first, MI)		Specimen ID Label *Place Specimen ID Label Here*
*Date of Birth	***PACTS NO.**	
*Status ◯ Pretrial Services ◯ Probation	*Supervising Federal Officer	
*Collection Date	*Collection Time AM/PM	Admitted Illegal Drug Use by Offender/Defendant *If so, list substance(s) and date(s) with donor initial in space above.*
Medications [include date(s) taken]		Special Test Request ◯ Benzodiazepine ◯ Phencyclidine (PCP) ◯ Other: _____ Specimen to be forwarded to national contract lab for other special test.

Collector Comments
◯ Unobserved
◯ Appears Dilute BAC (if applicable) _____

OFFENDER/DEFENDANT CERTIFICATION	COLLECTOR CERTIFICATION
I certify the information I provided above is true and correct. I certify the specimen I have provided on this date is my own and has not been adulterated. The security seal was applied to the specimen bottle by me, and I have verified that the specimen identification on this form and the bottle are identical. Offender/Defendant Signature Date	I certify I witnessed the above offender/defendant provide the specimen identified by the Specimen ID Label on this form. I certify that the security seal was applied to the specimen bottle in my presence, and I have verified that the specimen identification on this form and the bottle are identical. Collector Signature Date

◯ Check if the above offender/defendant failed to provide a urine specimen, and fax this form to the supervising officer.

Staff Signature: Date:

LABORATORY USE ONLY

Specimen received intact? ☐ No ☐ Yes If yes, received by: _____ (staff initial)	Date Specimen Received
Accession Number/Barcode *Place Barcode Label Here*	

Test	POSITIVE	
Amphetamine	☐	☐
Cannabinoid	☐	☐
Cocaine	☐	☐
Opiate	☐	☐
Benzodiazepine	☐	☐
PCP	☐	☐

Test Date

Test Time

Reviewed By

NEGATIVE ☐

Creatinine ☐ Normal (> 15 mg/dL)
☐ Abnormal (≤ 15 mg/dL)

Specific Gravity _____

Laboratory Comments

GCMS Confirmation Specimen ID Number: Date Transferred:

SUBMIT ORIGINAL FORM TO LABORATORY